BERRIEN COUNTY HEALTH DEPARTMENT
better health. stronger communities.

FREE School Vision Screening

To assist the technician, please complete the following:

Screening Date: _____ **Grade:** _____ **Teacher:** _____

Student's Legal Name_____Birthdate_____

Parent Name:_____Phone:_____

Mailing Address: _____

Has your child **ever** had an eye exam? ☐ YES ☐ NO
If YES, date of last exam:_____

When your child is ill or tired, do their eyes cross or one eye wander? ☐ YES ☐ NO

If yes, please explain: _____

_____

Does your child wear glasses/contacts? ☐ YES ☐ NO

Condition of glasses: ☐ New ☐ Good ☐ Broken ☐ Lost

If you have any questions please call (269)926-7121 ext. 5293 Melisa, ext. 5693 Danielle or ext.6525 Amber

HV-11 3/22/22

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